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THE POTENTIAL FOR SUSTAINED PROVISION OF HEALTH SERVICES BY SECTOR PVOs IN THE DOMINICAN REPUBLIC:

An Economic and Institutional Analysis

by

GERARD M. LA FORGIA
The Urban Institute

and

STEPHEN J. HEINIG
Abt Associates Inc.

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Abt Associates Inc., Prime Contractor
4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 USA
Tel: (301) 913-0500 FAX: (301) 652-3916
Telex: 312636

Management Sciences for Health, Subcontractor
The Urban Institute, Subcontractor

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ABSTRACT

This report is an economic and institutional analysis of the potential for sustained provision of health services by sector private voluntary organizations (PVOs) in the Dominican Republic. A sample of 12 Dominican PVOs, chosen to illustrate variations in size, mission, and scope, were assessed to determine the extent, effectiveness, and efficiency with which they provide maternal and child health care and family planning services to the community. The PVOs studied were: ACEBIEN, ADOPLAFAM, BUEN SAMARITANO, CARE/DR, CIAC, COIN, FEDES, FH, FUDECO, IDDI, MUDE, and PROFAMILIA.

Unlike earlier investigations of PVOs and their roles in society, this report viewed PVOs as possible alternatives to governmental units, due to the shortcomings of the current Dominican Ministry of Health (SESPAS). The study takes on added significance because of USAID plans to reduce financial support for health sector activities in the next few years. These plans will adversely affect those PVO operations that are strongly dependent on USAID support, forcing them to look elsewhere for resources, to reduce costs, or to eliminate some public services.

The authors interviewed the PVOs and examined internal records to determine their strategies, administration, programs, services, and beneficiaries. They also examined the management capacities of the PVOs and the success rate of their incentive systems to improve the effectiveness of semi-volunteer workers. PVO methodologies, institutional capacities (including information management systems), and coordination were also addressed. Based on the information obtained, the authors proposed options to expand or sustain the ability of the PVOs to continue their services in terms of financing and efficiency. Some of the options for PVO sustainability could be:

- Diversifying sources of revenue;
- Strengthening regional PVO consortia;
- Developing alternative links with SESPAS; and
- Reviewing the effectiveness of both current volunteers and potential incentive systems.

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LIST OF EXHIBITS

LIST OF ACRONYMS

ACEBIEN	Acción Empresarial para el Bienestar de los Asociados
ADOPLAFAM	Asociación Dominicana de Planificación Familiar, Inc.
AED	Acción Evangélica de Desarrollo
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
AVSC	Association of Voluntary Surgical Contraception
CARE	CARE Dominicana
CARITAS	CARITAS Dominicana
CCAP	Conocimientos, Creencias, Actitudes y Prácticas
CEICES	Centro de Entrenamiento e Investigación en las Ciencias Económicas y Sociales
CENISME	Centro Nacional de Investigaciones en Salud Maternal Infantil
CIAC	Centro de Acción y Apoyo Cultural
CMI	Comité Infantil de Región 4
CODECO	Colegio Dominicano de Economistas, Inc.
COIN	Centro de Orientación e Investigación Integral
CONOPOFA	Consejo Nacional de Población y Familia
COSASO	Coordinadora de Salud del Suroeste
DHS	Demographic and Health Surveys
FEDES	Fundación Educación y Desarrollo, Inc.
FH	Fundación Contra el Hambre
FP	Family Planning
FUDECO	Fundación para el Desarrollo Comunitario, Inc.
FY	Fiscal Year
GODR	Government of the Dominican Republic
HM	Health Messenger, Promoter (COIN)

HML	Health Messenger Leader
IDDI	Instituto Dominicano de Desarrollo Integral
MCH/CS	Maternal and Child Health and Child survival
MCH/FP	Maternal and Child Health and Family Planning
MIS	Management Information System
MOH	Ministry of Health
MUDE	Mujeres en Desarrollo Dominicana, Inc.
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PLANSI	Plan Nacional de Sobrevivencia Infantil
PROCETS	Program to Control Sexually Transmitted Disease
PROFAMILIA	La Asociación Dominicana Pro Bienestar de la Familia
PVO	Private Voluntary Organization
PVO/CSOPP	PVO Child Survival Operations Support Project
RD ($)	Denominated in Dominican Pesos
SAVE/PSI	Save the Children Foundation/Child Survival Project
SEEBAC	Secretaría del Estado de Educación y Bellas Artes
SESPAS	Secretaría del Estado de Salud Pública y Asistencia Social
SSID	Servicio Social de Iglesias Dominicanas
STD	Sexually Transmitted Disease
STP	Secretaría Técnico de la Presidencia
TRSX	Trabajadores and Trabajadoras Sexuales
URC/CS/PSI	University Research Corporation/Child Survival Project
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

The Health Financing and Sustainability (HFS) team examined a sample of private voluntary organizations (PVOs) in the Dominican Republic to assess the extent, effectiveness, and efficiency with which PVOs provide maternal and child health care and family planning services (MCH/FP) to their beneficiaries. This HFS study was intended to serve as prelude to a proposed USAID/Dominican Republic (DR)-financed Family Health Project, which would, in part, increase the sustainability of MCH/FP services provided by PVOs. However, this project was subsequently canceled by USAID/DR.

This study takes on added importance for PVOs currently receiving funding through USAID/DR-funded health projects. USAID plans to reduce its financial support for health sector activities in the 1990s. PVO operations that are strongly dependent on USAID support will have to generate resources from other sources, reduce costs, or curtail services and coverage in the communities in which they are active. We consider PVO executives and their donors to be the principal audience for this report.

A sample of 12 Dominican PVOs was selected to reflect differences in size and scope of operations. Two PVO coordinating bodies were also examined. Several of the PVOs do not provide actual MCH/FP services, but do provide other health, nutrition, and education services. Most of the PVOs provide maternal and child health services and have received USAID/Dominican Republic support, five of them through the Child Survival Project.

The HFS team documented the PVOs' objectives, strategies, administration, programs, services, and beneficiaries. Information was collected through interviews with staff and beneficiaries, and through examination of PVO records. Records provided data on the volume of MCH/FP services and economic resources used to deliver these services.

Community-based promoter networks are the most common delivery mechanism, working as conduits for mass-education campaigns, for monitoring the health of infants and mothers, and for distribution of MCH/FP materials. Other interventions include preventive health care, community education, and, in one case, social marketing.

The HFS team examined ways to expand and sustain the capacity of PVOs to deliver maternal and infant health and family planning services. Sustainability of PVO interventions was examined along two dimensions: financing and efficiency.

Financial sustainability may be linked to a PVO's ability to achieve a workable balance of financing arrangements. In other words, a PVO that can derive a significant share of income from two or more categorical sources — international (and local) donors, government, and market revenues — has a greater opportunity for institutional and programmatic sustainability. Other opportunities for sustainability concern alternative methods for financing the delivery of MCH/FP services, including cost recovery, or cross-subsidization from revenue-generating micro-enterprises.

The HFS team attempted to analyze financial data to calculate the resource costs per unit of MCH/FP services delivered; in most cases, however, expenditure and service data was kept separately by the PVOs, with no data for allocating administrative and other costs to service provision. For one PVO, an ad hoc study of unit resource costs for family planning services had been completed.

The study also examined the management capacity of PVOs to control an expanded MCH/FP program, and the use of incentive systems to improve the effectiveness of semi-volunteer workers. Appropriate options for strengthening the capacity of PVOs to provide MCH/FP services are:

- Seek a balanced financial strategy, integrating donors, Government of Dominican Republic, and market income sources, and do not rely on a single source of revenue;
- Strengthen regional PVO consortia and promote coordinating at the national level;
- Develop alternative links with the Ministry of Health (SESPAS) from those that have been established in the past, and
- Investigate the effectiveness of volunteer promoters providing MCH/CS and FP services, and examine possible incentive systems for promoter participation.

In general, the PVOs are strongly dependent on international donors. Income and expenditure data normally relate to donor specifications, with major administrative and capital expenditures accounted separately. As noted above:

- Data on service provision and resource costs were often lacking;
- Impacts of PVO interventions on the status of community health are not systematically monitored, and
- Existing information systems constrain the expansion of MCH/FP programs.

The PVOs are also developing greater experience with coordination, and have formed various types of consortia. Officials with regional PVO consortia described efforts taken through democratic processes to coordinate, implement, oversee, and evaluate PVO programs. This coordination could also increase effectiveness and efficiency of PVOs' programs by eliminating duplication of effort and coverage, pursuing economies of scale, and otherwise decreasing the resource costs of service delivery.

A major distinction marks this study apart from earlier investigations of PVOs. Typically, earlier studies examine the performance of PVOs in terms of their comparative advantages — what PVOs do relatively more efficiently than governmental or private organizations; sometimes, studies have examined the *absolute* advantages of PVOs — what these organizations do better than anyone else, in all places and times. This study examined PVOs as an alternative to

governmental organizations, given the critically impaired efficiency of the Dominican Republic's public health services.

1.0 INTRODUCTION

Sustainability is a multi-faceted issue that arouses both interest and controversy. The concept appears to possess universal appeal among international aid and charitable organizations. These donors regard sustainability as a pivotal element of development programs because without it, many argue that significant long-term improvements are difficult to achieve. By this account, sustainability refers to the long-term performance of a project, particularly after donor assistance terminates.

What does it take for a recipient of donor assistance to become "sustainable" at a future point? Which characteristics of an organization, program, or activity may foster or constrain sustainability? To answer these questions, analysts generally have focused on government health service systems or large-scale government-affiliated health projects receiving substantial financial and technical support from donors (Bossert, 1990; Honadle and VanSant, 1985; White, 1987).

Bossert (1990) offers the most comprehensive analysis of health project sustainability to date. In his review of USAID-funded health, population, and nutrition projects in Africa and Central America, Bossert measured sustainability in terms of the continuation of activities three years after USAID technical and financial assistance terminated. The following characteristics are seen to raise the probability of sustainability:

- Goals are clearly defined but negotiated between donors and recipient institutions;
- Program is integrated into established institutional structures and operations (e.g., health ministry);
- Sufficient institutional capacity exists to manage program activities;
- Program generates financial resources on a continual basis, and
- Activities address real or perceived needs of beneficiaries.

Nevertheless, most of projects examined by Bossert involved strong dependence on government funding after the withdrawal of USAID support. To be sure, post-project sustainability was related to the continued or increased contribution of resources by government. This was especially the case in Central America where the projects were managed by parastatals and PVOs closely linked to ministries of health (MOH), or by the health ministries themselves. Therefore, some of the lessons outlined by Bossert may have little relevance in a situation in which government participation is minimal or non-existent. As

suggested above, this is the case for USAID-supported PVOs as well as for nearly all health sector PVOs in the Dominican Republic.[1]

Although the presence or absence of one or more of these characteristics does not guarantee or doom the possibility for long-term performance, taken together they can represent a prescription for sustainability. It is generally accepted, however, that issues related to financing are key determinants of sustained activities upon termination of external assistance (Bossert, 1990; Cross, 1992). If projects are unable to produce services efficiently or tap alternative sources of finances, it is unlikely that they can maintain similar levels of coverage and service provision after donor departure.

The findings reported here are based on a sample of 12 PVOs providing MCH/FP, health, nutrition, or education services in the Dominican Republic. These PVOs are private, non-profit organizations that are independent of government and pursue activities and services aimed at improving the health of the poor. Many are financed by USAID and other external donors. As used here, sustainability relates to continuing the flow of activities or benefits after the formal (USAID) project terminates.

Broadly, this study was designed to assess *the potential for sustainability* of health services PVOs provide: how they finance them, how effectively they provide them, their resource requirements, and how PVOs manage both resources and service delivery. The chief intent was to identify constraints and opportunities to achieve greater sustainability through exploring alternative sources of financing, improving efficiency, and increasing effectiveness of PVOs providing health and family planning services.[2] How to expand PVO capacity to provide more of these services to Dominicans who need them most is another aim of this report.

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[1]Government represents a significant source of funding for only one of the 12 PVOs examined in this study. The experience of the AID-funded PVO Child Survival Operations Support Project (PVO/CSOPP) suggests that turning over PVO project responsibilities to the government at the end of the project cycle is generally not an option, unless such a measure was incorporated into the original project design (Personal communication, Dori Storms, 11/18/92). Though, in some cases, community or grassroots organizations can assume responsibility if these groups have received the appropriate training and are eager to continue project activities. Although documented evidence is lacking, PVO/CSOPP experience suggests that in addition to obtaining alternative sources of financing, other key factors affecting PVO sustainability include: perceived effectiveness of activities within the communities, managerial and technical capacity of the PVO, type of services provided, and efficiency. Regarding this latter point, decision making based on knowledge about costs is considered particularly important.

[2]Due to the unavailability of cost and outcome data from most PVOs, measuring effectiveness was an impossible task.

1.1 THE EXPANDING ROLE OF PVOS IN THE DOMINICAN REPUBLIC

PVOs occupy a major position in the portfolios of major international donors (USAID, 1988; Paul and Israel, 1991). Governments, donors, and PVOs themselves are interested in extending the range of services provided by PVOs and expanding their activities to larger populations (Paul, 1991). This is particularly the case in the Dominican Republic where donors have targeted PVOs for large-scale operations previously reserved for government agencies.

The designation of PVOs as a major operational conduit for donor-supported activities in the Dominican Republic is relatively recent.[3] Before the late 1980s, SESPAS was the principal donor recipient within the Dominican health sector. Since that time, however, donors have found it increasingly difficult to collaborate with SESPAS, as decision making affecting resource allocation, management, and service delivery in donor-supported programs fell victim to favoritism, patron-client alliances, and short-term political expediency.

International aid agencies in the Dominican Republic are increasingly relying on alternative, non-governmental channels to implement health programs. For example, by 1990, USAID/Santo Domingo channeled a large proportion of the health sector fund through PVOs. PVOs are the only recipients of USAID/Santo Domingo financing for child survival, family planning, and AIDS programs. Other donors have followed suit, increasing their linkages to PVOs while decreasing their level of collaboration with government agencies.

Little systematic analyses, however, exist on these organizations in the Dominican Republic or elsewhere. This relates to the diversity of PVOs as well as to the lack of available information. In particular, no information exists on costs and financing of these organizations. Referring to the PVOs in developing countries, Paul states (1991:12):

> NGOs [PVOs] are not a homogeneous lot; there is no consensus on the definition of NGOs. Severe problems exist in gathering and analyzing available information. Being small, most NGOs lack systematic records, even on their own operations, growth, and financial transactions. We know little about total capital invested, sources of financing, manpower employed, and the quantitative and qualitative dimensions of NGO activities, even on a country basis.

[3] A recent survey found 95 Dominican PVOs active in the health sector; half were established during the 1980s (PAHO, 1991).

1.2 PVOs AND SUSTAINABILITY

Many health sector PVOs in the Dominican Republic are wholly subsidized by international donors. Uppermost in the minds of PVO executives is how to maintain the flow of activities and benefits with decreased financial support from donors. USAID/Santo Domingo represents a major source of financing for most of the PVOs under study here, but plans to significantly reduce its financing of health sector activities in the early 1990s. Many PVOs under the USAID umbrella face the possibility of eliminating or at least drastically reducing their programs and activities. This is particularly the case for the PVOs participating in USAID's Child Survival Project (URC/PSI). How to tap alternative sources of financing and generate funds through alternative mechanisms are high priorities for PVO managers. Managerial and technical deficiencies also are key concerns.[4] An important question facing USAID is what it can do to prepare the PVOs to sustain health activities without its financial and technical support.

PVO executives recognize that their ability to provide services over the long run is strongly associated with sustained levels of financing. Threatened with extinction, some PVOs are scrambling to establish linkages with multiple donors. This strategy, however, may represent a short-term solution to a long-term problem as an increasing number of PVOs compete for a declining pool of donor resources. This study shows that lack of knowledge about costs may severely limit their ability to make decisions related to expanding or reducing the level and scope of activities. Another question relates to whether the PVOs should first attempt to analyze their costs (and perhaps lower them) before exploring methods to cover (or recover) them.

Few PVOs have addressed how to generate resources through alternative (non-donor) financing mechanisms.[5] To what extent can donor dependency be reduced? Based on the experience of some PVOs, this study provides insight into potential financial alternatives.

PVO representatives also recognize that other factors may also contribute to long-term performance. It is generally accepted among PVOs that programs that are well-integrated into the community, linked to local organizations, are efficiently administered, and perhaps most importantly, technically effective or at least perceived as effective by their clients, are more likely to continue after external funding ceases. Linkages to government and to other PVOs also are viewed as important factors contributing to institutional and program sustainability.[6]

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[4]These issues were recently confirmed in a survey of PVOs participating in the USAID Child Survival Project (URC/PSI, 1991). Several directors fear that the PVOs themselves face extinction if alternative financing sources are not found.

[5]One conclusion of a recent symposium of non-government organizations in development referred to the need for NGOs to diversify their sources of financing to decrease their dependency on donors (Gordon Drabek, 1987).

[6]Another issue of concern to PVOs is whether sustainability will be nurtured or imposed by the donors.

1.3 APPROACH

Whereas previous analyses (e.g., Bossert, 1990) examined sustainability through a retrospective and comparative review of experiences (in which the presence or absence of activities after the termination of external assistance was the key measure of sustainability), this study employs a more prospective approach. Since most of PVOs under study here are highly dependent on a single or limited number of external sources for funding and technical assistance, the key issue for these organizations is how to survive or maintain current levels of services in the not-too-distant future with reduced external assistance. Therein lies the two overall objectives of this study: (1) assess the potential for sustainability of PVO health services through an assessment of current financial mechanisms, administrative and technical capacity, and efficiency of service provision; and (2) based on the experiences of PVOs in the Dominican Republic and elsewhere, outline short- and long-term strategies to achieve sustainability.

In assessing PVO levels of financing and efficiency, the HFS team tried to ascertain any evidence or opportunity for achieving sustainable PVO activities. More specifically, the HFS team examined evidence or opportunity as they relate to:

- Coordinating PVOs and building PVO-PVO and PVO-SESPAS linkages to eliminate duplication of effort, promote economies of scale, or better exploit comparative advantages and unique abilities of these organizations;

- Developing alternative sources of financing to enable PVOs to provide services after donor assistance terminates;

- Improving managerial capabilities to facilitate the monitoring and evaluation of costs, service production, and impact, and

- Employing incentive systems to improve the effectiveness of semi-volunteer workers.

The financial and managerial analysis of PVOs pursued the following objectives:

- Document the PVOs' missions, development approaches, managerial capacity, services and programs provided, and their beneficiaries.

- Itemize the MCH/FP-related services provided by the PVO and measure the volume of services provided, and trace the program mechanisms for providing them and the target beneficiary population they serve.

- Collect data on the economic resources used to deliver these services, and what monetary or other income PVOs receive.

- Analyze the financial and service data to determine (where possible) the unit resource costs for providing MCH/FP services for measuring efficiency.

- Analyze the institutional and financial data for evidence of expansion of capacity, inter-agency cooperation, and sustainable development.

USAID and PVO officials are the intended audience of this study. Both groups recognize the need to develop strategies to cover PVOs' core and program costs to continue the delivery of services to beneficiaries. In the absence of the government's ability to provide these services in the areas where PVOs operate, usually poor rural and periurban communities, sustainability of PVO operations takes on added significance.

This report is divided into five sections. Section 2 describes the sample and data collection methodologies used for this study. Section 3 analyzes the administrative capacity of the PVOs, focusing on financial and information management systems. Section 4 reports on financial sustainability through an analysis of expenditures, resources, and cost recovery mechanisms. Coordination among PVOs and between PVOs and SESPAS is the subject of Section 5. Section 6 describes the variety of incentive systems used by a subset of PVOs to motivate community-based promoters. The references for this paper provide a list of interviewees. The 12 PVOs sampled for this study are described briefly in Section 1.4.

1.4 DESCRIPTION OF THE PVOs AND MCH/FP PROGRAMS

The authors studied a sample of 12 PVOs, 10 of which manage health activities within their programs. Exhibit 1-1 compares the PVOs in the sample in terms of staff, total expenditures for fiscal 1990, geographical areas of operation, and year founded. Several of the PVOs in the sample participate in AID's Child Survival Project. These include Asociación Dominicana de Planificación Familiar, Inc. (ADOPLAFAM), The Fundación Contra el Hambre (FH), Mujeres en Desarollo Dominicana, Inc. (MUDE), The Fundación para el Desarollo Comunitario, Inc. (FUDECO), and The Instituto Dominicano de Desarrollo Integral (IDDI).

ADOPLAFAM and the Asociación Dominicana Pro Bienestar de la Familia (PROFAMILIA) are primarily dedicated to providing MCH/FP services. Both maintain community-based programs for the promotion and distribution of family planning methods. Both support and operate clinics for MCH/FP services, although these clinics provide additional medical attention to families and individuals. Clinics also attend to medical emergencies. ADOPLAFAM, in addition to providing MCH/FP services, manages an AIDS intervention program including education about the disease and distribution of condoms.

EXHIBIT 1-1
SUMMARY CHARACTERISTICS OF SAMPLED PVOs

PVOs in Sample	YR	Staff (no.)	Geographical Area of Operation	Total Expend. US $000	Health Services	USAID supported
ACEBIEN (a)	1989	94	SD/SGO	1,500	food sales	no
ADOPLAFAM	'86	25	SD	190	MCH/FP	yes
BUEN SAMARITANO	'84	27	bateyes	NA	MCH/Nut.	no
CARE/DR (b)	'64	93	WF	773	MCH/Nut.	yes
CIAC	'79	10	bateyes	91	MCH	yes
COIN (c)	'87	20	cities/ bateyes	155	AIDS Ed.	yes
FEDES (d)	'86	18	SD	74	(none)	no
FH	'79	44	WF	261	MCH/CS/Nut.	yes
FUDECO (e)	'79	73	WF	605	MCH/CS	yes
IDDI	'85	70	SD	550	MCH/CS	yes
MUDE	'75	71	WF/Cibao	387	MCH/CS	yes
PROFAMILIA	'65	126	national	1,343	MCH/FP	yes

SD: Santo Domingo; SGO: Santiago; WF: Western Frontier Region
Cibao: Central Region; Bateyes: sugar plantations

NA means not available.

(a)ACEBIEN expend. for 1991; primarily nutrition.
(b)CARE expend. excludes capital expend., depreciation, value of distributed PL-480 food items.
(c)COIN expenditures for two programs only, in 1991; other expenditures not available.
(d)FEDES/CEICES expenditures estimated for 1989.
(e)FUDECO expend. by FY, mid-1989 to mid-1990. Does not include capital costs and depreciation.

SOURCE: PVO DOCUMENTS, PERSONNEL. Staff sizes are numbers of salaried workers on payroll. Expenditures are in rounded US$ for 1990 unless otherwise noted. Health expenditures include FP and exclude food and nutrition, sanitation, and water.

PROFAMILIA maintains a referral program through associated clinics for voluntary sterilization, and a social marketing program for the distribution of oral contraceptives and condoms through Dominican retailers. PROFAMILIA is a leading organization that also provides mass education via broadcast media and epidemiological and other studies, always topical to family health and planning.

The Centro de Orientación e Investigación Integral (COIN) is primarily dedicated to combating AIDS and other sexually transmitted diseases (STDs) through a network of community-based distribution of condoms, and health promotion and education. COIN also maintains medical clinics, in cooperation with the Government of the Dominican Republic (GODR).

The following PVOs — CARE, IDDI, FH, Buen Samaritano, Centro de Acción y Apoyo Cultural (CIAC), MUDE, and FUDECO — provide health care and MCH services as a component of a broader, integrated development strategy.

CARE is one of the oldest and largest PVOs operating in the Dominican Republic. Its development strategy focuses principally on food distribution and nutrition. In 1990, CARE began complementing its program for food supplementation with programs for health education interventions and preventive and primary health care. CARE coordinates efforts with SESPAS medical clinics, targeting infants, lactating mothers, and pregnant women as program beneficiaries.

IDDI promotes both MCH and FP through community education, through monitoring of infant growth and other indicators of child health, and through promotion of contraceptive methods and referral services. It also maintains a health center staffed by a pediatrician. IDDI's health program takes place in the context of efforts for social and community organization, micro-enterprise development, and infrastructure building.

FH provides nutrition and MCH education, medical care, and food supplements to children under five, women of fertile age, and school children, also within a wider context for community development and agriculture.

Buen Samaritano and CIAC operate in the areas of the sugar plantations, known as bateyes. Buen Samaritano was itself established by physicians, and implements health education, medical services, nutrition, and sanitation programs. Its scope of activities includes, but is not limited to, MCH assistance. CIAC promotes occupational health in the sugar industry; its community health program has suspended operation since 1990.

MUDE focuses on women's development projects in rural areas. FUDECO implements integrated rural development programs in the western frontier, including appropriate technology and participatory institutions.

Both MUDE and FUDECO promote health education and monitor infant growth and vital statistics as part of their community development projects. Although MUDE and FUDECO emphasize MCH as a significant objective of their programs, these activities account for a fraction of total operating expenditures. The contribution of these organizations to overall health care grows significantly if one measures improvement in ambient factors of nutrition, sanitation, community organization, level of education, and family income in the health status of their beneficiaries.

The remaining two PVOs in the sample maintain no MCH/FP programs. Acción Empresarial para el Bienestar de los Asociados (ACEBIEN) is a financially self-sustaining PVO with the largest financial budget in this sample. It is a *social good business* that provides food coupons and other benefits to urban workers.

The Fundación Educación y Desarrollo, Inc. (FEDES) is a self-sustaining PVO that educates and trains organizations in business administration. Its courses and experience intersect many of the requirements for capacity building and promoter training faced by other organizations. FEDES activities may represent an economy of scale that could be capitalized by PVOs working in concert.

Exhibit 1-2 summarizes the missions and activities of the PVOs for the reader's convenience in recollecting these 12 organizations as they are mentioned throughout the text.

EXHIBIT 1-2

SUMMARY OF SAMPLED PVOs' MISSIONS AND ACTIVITIES

- ACEBIEN is a social good enterprise that does not provide specific MCH/FP services. It manages extensive food distribution programs.
- ADOPLAFAM delivers family planning service and provides MCH and other health services through clinics.
- Buen Samaritano implements health education, medical services, nutrition, and sanitation programs in the bateyes, or plantations.
- CARE integrates nutrition and food distribution programs with delivery of preventive health care for maternal and infant health care on the western frontier.
- CIAC chiefly promotes occupational health in the sugar industry.
- COIN directs AIDS and other STD interventions in several areas of the Dominican Republic.
- FEDES is a management-education PVO in Santo Domingo.
- FH operates MCH and other health and nutrition programs within communities on the western frontier.
- FUDECO operates integrated rural development programs along two regions on the Western Frontier.
- IDDI manages integrated community development, including micro-enterprise development and MCH/FP services, in two communities in Santo Domingo.
- MUDE implements integrated women's development programs mostly in rural communities.
- PROFAMILIA delivers family planning and family health (especially MCH) services nationally. It maintains two large clinics in Santo Domingo and Santiago.

2.0 METHODOLOGY AND ACTIVITIES

To meet the objectives described in Section 1.4, the HFS team performed case studies of the 12 PVOs. Field teams visited PVOs to collect general information and data relating to production of services, costs, resource use, beneficiaries, and coverage. Information was collected through interviews with PVO directors and department heads, and from bookkeeping and other records that the organizations voluntarily released. In most cases, information was supplemented by interviews with other PVO staff, promoters, and beneficiaries. Interviewers allowed for discussion and open-ended responses; each issue raised was revisited several times within each PVO. Interviewees are listed following bibliographic references.

The number of PVOs to be examined was increased during the course of this study. Originally, USAID selected five PVOs when specifying the scope of the investigation. The original sample, however, was comprised entirely of large PVOs with incomes of approximately US $500,000 per year or more, and closely tied to the international community. USAID staff and the HFS team chose to expand the study to include smaller PVOs, as many of the acclaimed virtues of these organizations — innovation, grass-roots organization, low overhead — are purported to be more prevalent among smaller PVOs than larger ones. Consequently, seven small, non-traditional PVOs were added to the original sample of five. Two additional organizations, Comite Infantil de Region 4 (CMI) and Coordinadora de Salud del Suroeste (COSASO), representing associations of PVOs, were also included in the study to assist assessment of PVO coordination. These associations are examined in Section 5. All PVOs in this study keep their headquarters in the National District, the province surrounding Santo Domingo, although most conduct activities elsewhere in the country. Efforts to include PVOs based in other provinces failed due to the unavailability of those PVOs contacted and time constraints.

2.1 SERVICES AND OUTCOMES

Interviewers sought information on the volume, type, effectiveness, and impact of services provided by the PVOs. PVOs do not routinely measure the impact of services they provide or implement a system for monitoring impacts. PVOs assume that the production of their services provide a net social benefit. They focus their operational energies on securing finances and providing services. Consider that the same is true for most private businesses; grocery stores do not measure their impact on neighborhood levels of hunger and nutrition. Even as PVOs redefine their programs, they do not appear to base new strategies on quantifiable studies of the target population, but on other factors, including the reception of new programs by donors. The PVOs' chief way of measuring impact is growth; do their programs grow, and do they attract new participants or new donors?

2.2 UNIT COSTS

The investigation team was also charged to ascertain, where possible, the unit costs incurred by the PVO in providing MCH and FP services. In only one

case, PROFAMILIA, did an organization have an available unit cost of production for services. Unit costs of family planning services for PROFAMILIA were available from a time-motion study by Bratt and Janowitz (1991).[7]

Aside from the Bratt study, unit costs for MCH services and for all other PVOs were consistently unavailable. The present study relied on securing derivative information for gauging the efficiency with which the PVOs provide services.

- First, total services provided (output) were assessed from available measurements.
- Second, financial expenditures were assessed from available accounting and bookkeeping records.
- Third, economic expenditures were assessed, that is, resources utilized by the PVO which present no monetary expenditure for the PVO, such as donated office space and donor-provided vehicles.
- Where FP/MCH services represent a fraction of a PVO's activities, the proportional allocation of resources to FP/MCH was estimated.

In all cases, PVO records did not offer complete information for the calculations of unit costs of MCH/FP services.

[7]John H. Bratt, Barbara Janowitz, Diznarda Almonte, Juan Faustino Polanco, Servio Perez, and Milton Cordero., Costs of Family Planning Services Delivered Through PROFAMILIA Programs, Sept. 13, 1991. Family Health International and Family Planning Association of the Dominican Republic (PROFAMILIA). Data for the study was collected principally in the Fall of 1990.

3.0 INSTITUTIONAL CAPACITY

This section assesses the capacity for management of service and financial information found within the PVOs. "Institutional capacity" is defined here as the PVO's ability to produce and expand its level of output, and the types of output it produces.

Donor financing was identified by PVO directors as the chief constraint to operations (Section 4. examines PVOs' sustainability and development of alternative sources of financing). However, other factors may also restrict PVO development. As the HFS team gathered information on the volume of services produced by PVOs, their ability to target those services effectively, and the resources required to provide them, the team found constraints within PVOs internal systems for measuring inputs and outputs. A major constraint of PVO operations, as confronts donors, is the PVOs' inability to collect and manage timely information on the production of services and utilization of resources. Without sufficient information on services and resources, donors cannot assuredly gauge the level and effectiveness of services the PVOs provide.

Sections 3.1 describes the general types of PVO-produced MCH/FP services and service mechanisms, to help clarify the types of activities in which the PVOs engage. The degree to which PVOs incorporate MCH or FP services within their overall mission varies greatly. Section 3.2 reviews the internal system for management information in providing services. Section 3.3 examines internal systems for finance information.

3.1 MCH/FP SERVICES

Those PVOs in the sample that provide MCH do so through three types of product:

(1) Basic health education, including nutrition and sanitary health practices, infant care, breastfeeding, etc.

(2) Monitoring, including recordkeeping of infant growth and other vital statistics, for children under five years old and pregnant women.

(3) Preventive and primary ambulatory medical services, including vaccinations, oral rehydration therapy (ORT), acute respiratory infection (ARI) therapy, and other treatment; also, referrals.

Family planning services were also provided by PVOs through three separate products:

(1) Education on contraception, including general medical risks and benefits of contraception, and of alternative methods. Also, counseling on emotional and moral considerations.

(2) Supply and re-supply of contraceptive methods.

(3) Provision of medical services, including consultations, examinations prior to use of contraception, installation of methods such as IUD or NORPLANT that require medical service, and follow-up and removal visits.

Mechanisms for the provision of services are closely identified with the product delivered, and include:

- Community-based promoters, trained and supervised by coordinators and other project staff. Promoters monitor the health of mothers and children, provide health and FP education, refer clients to clinics as merited, and supply, or re-supply, contraceptives (employed by 10 PVOs within the sample).

- Clinics and associated clinics for delivery of medical services, including examinations, prescriptions, and insertion of contraceptive methods (employed by five PVOs within the sample).

- Education activities including workshops, training sessions, town meetings, household visits, publications (newsletters, comic books), theater, social marketing, etc. (employed by 11 PVOs within the sample).

- Social marketing of products through commercial channels, such as advertising and distribution through retailers (employed by one PVO for family planning methods).

Of these three mechanisms, promoter networks are by far the most common deliverer of MCH/FP services, and represent the highest level of effort within the PVOs.

It should be noted at this point that the summation of PVO "products" and "mechanisms" in Section 3.1 describes a single aspect of PVO activities as focused upon by this study. For most of the PVOs, the products and mechanisms listed are single components of a broader strategy to enable communication, leadership, individual empowerment, and community development. Promoter networks and other PVO programs are vehicles for this strategy, and not strictly conduits for services measured here. The PVOs' ingenuity and multifaceted objectives are reflected in the disparate variety of promoters, which from PVO to PVO include rural women, mothers, children, hairdressers, agricultural workers, and prostitutes, among others.[8]

Section 1.4 describes the PVOs examined by this study.

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[8]FUDECO trains mothers and older children as health promoters for child survival; ADOPLAFAM promotes contraceptive methods through hairdressers and beauty salons; COIN trains prostitutes as health promoters in combatting the spread of AIDS.

3.2 INFORMATION MANAGEMENT CAPACITY

In planning for the expansion of MCH/FP services, it is helpful if PVOs measure the volume of services they presently provide and the resources consumed in providing them. Surprisingly, a number of the PVOs in the sample either do not measure this information, or do not measure it in a timely and consistent way. Exhibit 3-1 summarizes the presence of management information systems (MIS) within the sample.

EXHIBIT 3-1

PRESENCE OF MIS DATA WITHIN PVOs

PVOs in Sample	Prod. Data	Exp. Data	Impact Data
ACEBIEN	✓	✓	-
ADOPLAFAM	✓	✓	-
BUEN SAMARITANO	-	-	-
CARE/DR	-	✓	-
CIAC	-	✓	-
COIN	-	✓	-
FEDES/ CEICES	✓	✓	-
FH	-	✓	-
FUDECO	✓	✓	-
IDDI	✓	✓	✓
MUDE	✓	✓	-
PROFAMILIA	✓	✓	-

✓ = present; - = not present

The ability/inability to measure and monitor service provision is itself a key measure of institutional capacity. This and other capabilities to manage and provide information on services is considered here case by case. In many of these cases, service information is constrained by the mechanism which delivers the service. Prima facie, the provision of health education through household visits of promoters in rural areas or in barrios, will be more difficult to measure than consultations at a PVO-managed clinic in Santo Domingo. The product of an educational visit is harder to gauge; the ability to compare the productive value of one household visit to another, or the visit by one promoter or another, is more dubious.

The PVOs in the sample are considered in light of four questions of management information. First, to determine output, do they measure the volume and range of interventions they produce? Second, do they record who is receiving or using services, and what percentage of the target population is being served? Third, to determine the PVOs accomplishment of objectives, do they measure outcomes, or, if possible, impacts? The needs and abilities to collect information will vary greatly from PVO to PVO. The presence of some system for collection, however, is a telling indicator of PVO capacity.

Exhibit 3-2 presents a matrix within which the relative levels of information management are estimated. The MIS spectrum ranges from no formal collection of information to routine monitoring of the volume of services produced to routine determination of client coverage, satisfaction, and other outcomes, including impacts of the program. No PVO monitors actual impacts of its programs on the status of community health and development. It is both costly and intractable to perform such impact-analysis routinely, as a PVO would

need to disaggregate the effects of its own activities from all other factors correlated to any measured change in health or development status. Also, the PVO would require collection of baseline data prior to the implementation of programs. At best, PVOs, especially those operating in smaller communities, could monitor epidemiological changes, such as the decline in deaths of children under five, as an indicator to inspire confidence in its child survival or other health program. It would be difficult, and perhaps unnecessary, for the same PVO to determine the correlation of its own program on declining mortality; conversely, a rise in the rate of infant mortality would not of itself indict an active child survival program.

EXHIBIT 3-2

PVO INFORMATION MANAGEMENT CONTINUUM

	Intermittently Monitor Volume and Range of Interventions	Regularly Monitor Volume and Range of Interventions	Monitor Client Coverage	Monitor Client Satisfaction	Monitor Outcomes
ACEBIEN	✓	✓	✓		
ADOPLAFAM	✓	✓	✓	✓	
BUEN SAMARITANO	✓				
CARE	✓	✓	✓		
CIAC	✓				
COIN	✓	✓	✓		
FEDES	✓	✓	✓	✓	
FH	✓				
FUDECO	✓	✓	✓		
IDDI	✓	✓	✓	✓	
MUDE	✓	✓	✓		
PROFAMILIA	✓	✓	✓	✓	
Note: MUDE and FUDECO consider only Child Survival Project.					

One PVO in the sample routinely documents satisfaction of its participants and clients. The small management-education PVO, FEDES, measures service delivery, i.e., the number of student-hours of courses delivered, the volume of students matriculating, and the parent organizations of the trainees. At the end of courses, FEDES polls all students present to evaluate the quality of the instruction. FEDES does not directly determine if the students/trainees are more productive on return to the workplace. Nevertheless, FEDES considers repeat business from an organization to indicate a positive outcome in meeting the PVO's objectives. FEDES is a small organization delivering a single type of service within one area. Collection of output data is a practicable matter for the PVO. Further, its management has the expertise to appreciate and use the information it collects.

3.2.1 PVOs Reporting Client Coverage

Three of the PVOs, IDDI, PROFAMILIA, and ADOPLAFAM, monitor extent to which services reach clients, and have MIS systems in place to centrally monitor services. Client satisfaction is not systematically documented, although they each report various activities for pursuing client satisfaction. Each of these three monitored client coverage to some degree, although not always routinely.

IDDI provided the HFS team with data on program operations at all levels in one community, La Zurza. Similar information was not available in IDDI's second community, La Herrera. In 1988, IDDI conducted a socioeconomic and health survey of the two barrios in which it operates to obtain baseline data to contribute the planning and evaluation of program activities. In the delivery of MCH services, IDDI registers program participants, maintains records of activities, and to a lesser extent, assesses program impacts on health status. Semiannually, coverage is assessed through a census conducted by IDDI promoters in their catchment areas. Census records number the health and demographic characteristics, including household population by age and sex, child weight, prenatal care, and use of family planning methods. Promoters are required to present monthly reports on their activities and assigned families; all reports are entered into IDDI's automated MIS.

Neither ADOPLAFAM nor PROFAMILIA presented the same level of information on beneficiaries as IDDI. Both presented itemized lists of services as part of monthly and periodic reports. Both ADOPLAFAM and PROFAMILIA presented what appear to be occasional or ad hoc documents on the economic status of its target populations. Both have systems and personnel that closely monitor and supervise their promoter networks. Neither ADOPLAFAM nor PROFAMILIA documented that promoters systematically cover all of their catchment areas, while IDDI documents the entire population of its beneficiaries in at least one of its communities.

PROFAMILIA covers a broad geographic area of the country, and is the only PVO providing FP services outside of the capital's province. It has a network of over 600 promoters, a state-of-the- art computer network, and office staff assigned full-time to collecting statistical data on service provision. The HFS team examined only the activities of PROFAMILIA that concerned provision of MCH/FP and other health services, although the PVO has also performed vital epidemiological and demographic studies on unsatisfied need for family planning services and other topics. ADOPLAFAM provided complete service information from its clinics and community-based promotion to the HFS team. ADOPLAFAM's community promoters follow up on clinic referrals, and make periodic reports which provide a means to relay client satisfaction to the organization.

3.2.2 PVOs Reporting Quantity of Services

Four of the PVOs, MUDE, FUDECO, ACEBIEN, and CARE, provided information on the quantity of services provided, but did not present periodic documentation on the quantifying real levels of coverage. Both MUDE and FUDECO are participants in the Child Survival Program, and, as part of the program, monitor births and measure infant growth. This information is collected by promoters in PVO-provided notebooks, and appears to be used in the field for detecting life-

threatening situations and referring mothers and children to clinics and hospitals. This information was not as yet summarized at headquarters, nor was summary information available on the beneficiaries involved in the health education and promotion activities. Similarly, CARE also accounts for services provided, but not for populations served. CARE has relatively sophisticated financial and information accounting systems. CARE, FUDECO, and MUDE confine their activities to the western frontier region; the distance and the dispersed populations make beneficiary data more logistically difficult to obtain. ACEBIEN's beneficiaries are principally urban; the PVO does not routinely monitor beneficiary data. The PVO in many ways resembles a business and measures its success through growth rather than through community impacts.

The description of COIN on the matrix in Exhibit 3-2 is problematic. The HFS team was unable to collect centralized reports on the monitoring of beneficiaries, although other COIN documents report that baseline data has been collected to measure the effectiveness of its AIDS-education interventions. The PVO conducted a survey of behavior, knowledge, beliefs, and attitudes of its target, beneficiary population of at-risk individuals. COIN will re-survey the population after implementation of its intervention to measure the change in awareness and response to AIDS. Moreover, COIN coordinates activities with other PVOs and SESPAS, and has been contracted to provide logistic support for a smaller, emerging PVO. By all indications, COIN appears to be a sophisticated PVO, and by its linkages with other PVOs, a possible model for PVO-PVO and PVO-SESPAS cooperation. The HFS team, however, was unable to obtain documentation of certain services (such as clinical consultations), and of extent of coverage within the beneficiary population.

3.2.3 PVOs Not Monitoring Output

FH does not appear to monitor program activities in part because it lacks a MIS for its community development centers. FH provided the HFS team with short case studies that broadly describe some program activities conducted in communities since FH's arrival. Before entering a community, FH performs an informal household survey of needs assessment. Information on program participants, continuity, and impact is unavailable. FH also is a participant in the Child Survival Program, and its activities on the program are essentially managed apart from the remainder of the organization. While cost information was available for this program, participant and beneficiary data was still lacking.

CIAC and Buen Samaritano also lack an MIS or other systematic reporting on the delivery of services. CIAC has made a greater effort than many PVOs to integrate research information dissemination and grassroots participation into its occupational health activities, but the lack of data on workers at each work site make any gauge of progress and beneficiaries difficult to measure. Relatively little information was available on operations and activities conducted by Buen Samaritano. In part, this stems from an institutional reorganization initiated in 1990. Since that time, most of the staff has been replaced and it appears that some program activities were interrupted. The institution lacks the rudiments of an information system. Aggregate data of any kind were not available.

EXHIBIT 3-3

PVO FINANCIAL MANAGEMENT CONTINUUM

	Develop Global Budget	Develop Program-Specific Budget	Allocate Overhead, Depreciation	Conduct Program and Budget Performance Analysis	Measure Unit Costs per Benefit or per Beneficiary	Measure Cost Effectiveness
ACEBIEN	✓	✓	✓	✓		
ADOPLAFAM	✓	✓	✓	✓		
BUEN SAMARITANO	✓	✓				
CARE	✓	✓	✓	✓		
CIAC	✓	✓	✓			
COIN	✓	✓				
FEDES	✓	✓	✓	✓	✓	
FH	✓	✓				
FUDECO	✓	✓	✓			
IDDI	✓	✓				
MUDE	✓	✓	✓			
PROFAMILIA	✓	✓	✓	✓		
Note: MUDE and FUDECO considers only Child Survival Project.						

3.3 FINANCIAL MANAGEMENT

PVO financial management was examined in terms of the answers to several questions. Do they track the total value of resources used in producing outputs? What unit of output or other indicator does the PVO use to gauge productivity? Over what time period is the information retrieved (e.g., weekly or monthly)? Is it retrieved routinely, and does the information trigger response by management? Do they budget expenditures in aggregate, separately by project, or by detail of expenditure? Do they allocate resources used per unit of output as well as the percentage of overhead and administrative resources used to produce each unit of service (presuming they have first identified a denominator, the unit of service)? Do they include capital assets and costs, depreciation, and the value of donated commodities in the tracking and allocation of costs?

Exhibit 3-3 illustrates a matrix for the collection of financial information, ranging from a single, undelineated global budget for activities to measuring cost effectiveness. As noted above, no PVO routinely measures effectiveness per unit cost of services. FEDES is the only PVO which periodically analyzes operations to determine the unit costs of service per beneficiary. PROFAMILIA performed an ad hoc study with Family Health International for USAID/Santo Domingo on the resource costs of family planning services delivered through PROFAMILIA (see Section 2.2).

PROFAMILIA, like ADOPLAFAM, ACEBIEN, and CARE, all conduct program and budget performance analysis, as shown in Exhibit 3-3. This analysis, short of a unit cost study, is a potential guide to efficiency, as the organizations can

use persistent discrepancies in budget and performance to identify inefficiencies.

CIAC, MUDE, and FUDECO all monitor income and expenditures across the organizations, including project and other funds. All three present balance sheets, including organizational assets and liabilities. These also include capital costs and depreciation. In none of these organizations were documents presented comparing budgets and actual costs.

Financial information for COIN and FH was specific only to donor projects; institution-wide costs were not aggregated. IDDI is a conduit for diverse sources of donor funding; more than half of IDDI's funding arrives from Plan International. IDDI's bookkeeping does not include separate accounts for indirect costs, but attaches an overhead charge on each project. It was not possible for the HFS team to discern fixed vs. concurrent costs, nor direct vs. overhead costs, including capital costs, incurred by the delivery of MCH/FP and other services. Buen Samaritano did not provide financial information to the HFS team.

3.4 SUMMARY OF INSTITUTIONAL CAPACITY

The expansion of MCH/FP delivered by PVOs is constrained by existing management information procedures and systems. While the PVOs are able to budget and manage their activities, few PVOs are able to determine the unit costs of the services they provide.

- In order to identify areas of inefficiency, economies of scale, and opportunities for coordination, PVOs need to determine the full resource costs invested per unit of service they provide. Presently, PVOs maintain resource information within accounting systems that were only designed to ensure that donor finances are managed in accord with contractual obligations. In short, the PVOs in the sample are responsive to donors; the systems they presently have are often the result of donor-initiated capacity building and project requirements. Of the PVOs in this sample, the three private voluntary providers of family planning services — PROFAMILIA, ADOPLAFAM, and IDDI — have made marked strides toward such systems.

- FEDES has demonstrated experience and capability to apply new management techniques to the functioning of PVOs. FEDES may be a model for designing programs to expand PVO management capacity and train PVO administrative staff. FEDES prefers dialogue to pedagogy, and could manage round-table discussions among PVOs and donors on the coordination of effort. FEDES could also train PVO administrators, coordinators, and clerical staff.

- The institutional capacity of PVOs in the sample was remarkably similar across PVOs, with most of the PVOs clustered about the same level of management. Section 5 considers opportunities for coordinating the expansion of this capacity among PVOs.

4.0 FINANCIAL SUSTAINABILITY: EXPENDITURES, COSTS, AND SOURCES OF INCOME

This section focuses on the financial aspects of sustainability. More specifically, it examines expenditures, costs, source of resources, and cost-recovery mechanisms. At the outset, it is important to emphasize that the type(s) of PVO-based interventions can influence the range of options related to financial sustainability. Most of the PVO programs under study here focus on health promotion and prevention. Some provide a combination of health promotion and commodity distribution (e.g., food or contraceptives). Charging fees for educational orientation activities is difficult and fees for foodstuffs donated by international aid agencies are prohibited. For the most part, the sampled PVOs do not provide curative care services. Several are active in public good activities such as sanitation and water supply (IDDI, FH, and FUDECO), as part of an integrated development approach. These programs are not examined here. In addition, fees, sales, and other income-generating activities run contrary to the development philosophy and religious mission of some PVOs. Pointing to the failure of government and market mechanisms, many PVOs target low-income groups which have little access (geographical and financial) to government or private sector services. They also stress the charitable nature of their work, or similarly, the voluntary nature of the development process.

4.1 EXPENDITURES

Total expenditures provide a broad, comparative measure of PVO size and institutional capacity. This section focuses on PVO recurrent or operational expenditures. Excluded from this analysis are capital expenses, costs of certain commodities, and cost of volunteer labor, as data related to the items were unavailable. ADOPLAFAM and PROFAMILIA sell contraceptives and condoms — donated by international agencies — through various promoter networks, while CARE distributes food at SESPAS rural clinics. The former PVOs are permitted to recover the cost of commodity management through user charges. CARE, however, is barred from applying fees of any kind for food items. FH sponsors teams of short-term volunteers from the US who participate in rural water supply, sanitation, and construction activities. Included in the analysis, however, are expenses related to commodity management and fielding expatriate volunteers.[9]

Exhibit 4-1 shows considerable variation in the 1990 expenditures for the PVOs in the current sample,[10] ranging from US $78,000 to $1.5 million. Expenditures are not a function of years of operation, sources of income, or type of PVO. ACEBIEN was founded in 1989, yet it is the largest PVO in terms of expenditures. Similar to FEDES, the smallest PVO in the sample, ACEBIEN derives all income from market revenues. CARE, the third-largest PVO, is fully dependent on donors. Expenditures appear to be related to geographical coverage and the nature of the goods and services provided. ACEBIEN, PROFAMILIA, and CARE, the three largest PVOs, are national-level PVOs that are involved in commodity distribution, but also operate health promotion and other health-related

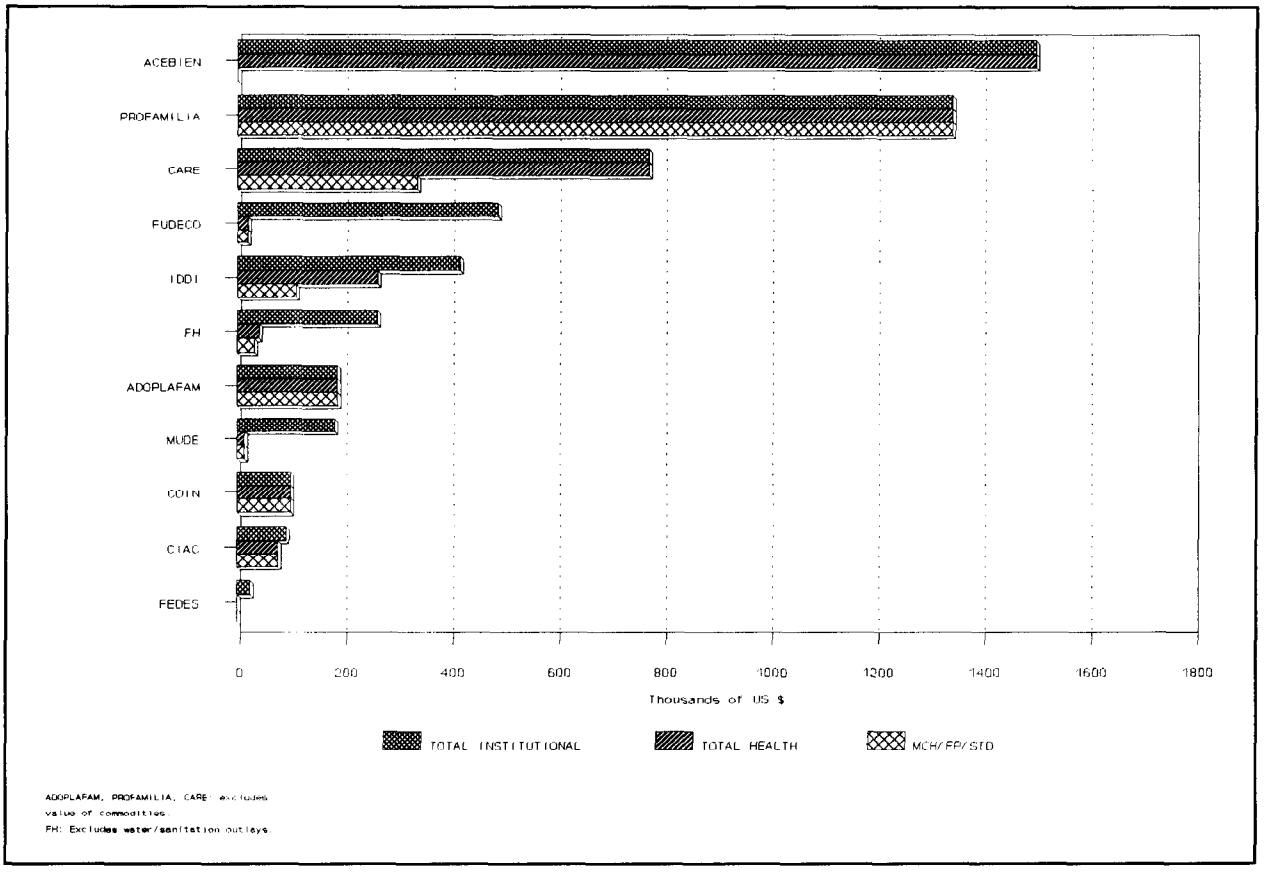
[9]Expenses for foreign technical assistance was included if paid for by a PVO.

[10]Financial data was unavailable for Buen Samaritano.

programs. In contrast, the PVOs with the least expenditures focus on a single category of interventions: CIAC, occupational health in the sugar industry; COIN, AIDS prevention; and FEDES, business administration training.

Exhibit 4-1 also demonstrates the proportion of total expenditures dedicated to health activities and to MCH/FP/STD programs. Outlays on overall health and MCH/FP/STD activities are estimates based on financial records provided by the PVOs. In several cases, it was difficult to separate health program expenditures from other programs and from general administrative costs. Methodologies used to allocate overhead expenditures to specific programs varied according to data availability. Outlays for overall health includes food assistance (CARE), water

EXHIBIT 4-1: PVO INSTITUTIONAL, HEALTH, MCH/FP/STD OPERATING EXPENDITURES, 1990



supply and sanitation (IDDI, FUDECO, CARE), and occupational health (CIAC). The figures exclude expenses for food production and animal husbandry projects. These activities generally are conducted within agricultural programs.

The expenditure breakdown demonstrates that PROFAMILIA, ADOPLAFAM, COIN, CARE, and ACEBIEN can be classified as exclusively health sector PVOs. Moreover, the former three focus exclusively on MCH, FP, or STD activities. ACEBIEN features the sale of food and drugs at discount prices, but provides no MCH/FP/STD services. CARE spends 44 percent of total outlays on an MCH program that includes a food distribution component. The rest of CARE's outlays support food supplementation activities in government schools. CIAC's major program is occupational health, representing over 90 percent of total institutional expenditures. FEDES is the only non-health PVO of the sample. The remaining PVOs — IDDI, MUDE, FH, and MUDE — define themselves as integrated development organizations. Expenditures are earmarked for health programs as well as for an array of activities that can contribute to improving health (e.g., agriculture, income generation, road construction, etc.).

4.2 DIRECT UNIT COSTS

Assessing cost effectiveness was impossible due to the absence of outcome data. Most do not maintain records that would enable the calculation of costs.[11] Nevertheless, a number of PVOs provided information on *potential* population coverage. Exhibit 4-2 compares potential per-beneficiary operating costs for child survival programs among five PVOs. Since real levels of coverage were unavailable, the results presented here should be interpreted with caution. The data refer to direct expenditures related to labor, training, maintenance, and supplies for a similar set of (MCH/CS) services. The figures do not include the cost of general and administrative support or the value of commodities (CARE). These indirect costs were excluded from the analysis because of the difficulty of distributing them across the various programs managed by each PVO.

EXHIBIT 4-2
PVO CHILD SURVIVAL PROGRAMS:
PER POTENTIAL BENEFICIARY DIRECT COSTS, 1990
(in US $)

PVO	PER BENEFICIARY OPERATING COSTS[a]	FAMILIES/ PROMOTER	PROMOTERS/ SUPERVISOR	MONTHLY CASH INCENTIVE
CARE[b]	$8.60	(e)	18	$265.20[f]
IDDI[c]	8.15	30	27	8.00
FH[d]	4.31	43	21	in-kind[g]
MUDE	4.26	60	18	8.00
FUDECO	3.61	40	20	4.60[h]

[a]Labor, training, maintenance, supplies, and other direct costs.
[b]Excludes cost of commodity purchase and management.
[c]La Zurza.
[d]Elias Piña.
[e]Care extension agents work with SESPAS personnel to cover families within the catchment area of SESPAS rural clinics.
[f]Also receive health insurance, gas allowance, and per diem.
[g]Food and clothes on as-needed basis.
[h]Food and transport allowance.

The direct costs for IDDI and CARE are double those for FH, MUDE, and FUDECO. These latter three PVOs provide similar MCH/CS services in rural areas close to the Haitian border. Yet FUDECO displays the lowest per beneficiary

[11]Only one PVO (FEDES) provided information on unit costs.

cost, 15 percent less than FH and MUDE. The average per-beneficiary cost of the five PVOs displayed in Exhibit4-2 is $5.79.[12]

The wide range of unit costs (for relatively similar activities) suggest differences in input composition and efficiency. Exhibit 4-2 also compares the PVOs in terms of three variables that contribute to the variation in costs (and can be directly manipulated by the PVOs): families per promoter, promoters per supervisor, and incentives provided to promoters. Teasing out the effects of these and other factors on total costs is difficult in part because a complete breakdown of costs was not available from the PVOs. CARE registers the highest expenditures, in part because it pays full salary and benefits to its promoters. According to program directors, IDDI's high outlays result from higher costs in urban areas, relatively high incentive pay (RD $100 monthly) to their promoters, and a low family-to-promoter ratio (30). On the other hand, although MUDE also provides RD $100 in cash incentives to its promoters, this PVO works in the more inexpensive rural areas and family-to-promoter ratio (60) is high. In general, FH, MUDE, and FUDECO demonstrate comparatively lower direct costs. This appears related to their higher ratios of families to promoter. FH and FUDECO also exhibit lower outlays in incentives for their promoters.

More in-depth analysis is required to provide a more rigorous estimate of per beneficiary costs and the influence of these and other variables. What is the effect of incentive systems on coverage, quality, and continuity of promoter-bases services? What is the relationship between incentives and promoter recruitment and turnover? What is the cost trade-off between (higher) incentives and (lower) family-promoter and promoter-supervisor ratios? Data and time limitations precluded even a cursory examination of these issues.

How much would it cost to extend MCH/CS to target groups at the estimated per-beneficiary (direct) costs? A simple exercise involving the two western frontier regions (IV and VI), targeted by USAID/Santo Domingo and other donors is instructive. Based on the lowest per beneficiary cost of US $3.61 (FUDECO, see Exhibit 4-2) and 1990 estimates of the population of malnourished children ages 0-4 (43,350) and pregnant and lactating women (33,046) in Regions IV and VI,[13] full extension would cost approximately US $341,000 in 1990. By way of comparison between 1988 and March 1991, the SAVE/PSI project had disbursed $84,700 to PVOs operating in two regions. Although this figure pertains to direct costs only, it may be overestimated. The estimate assumes resources required to cover an additional beneficiary remain constant (average cost = marginal cost). On the other hand, it excludes overhead and other administrative costs. This exercise also assumes no SESPAS participation.

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[12]In comparison, the PVO Child Survival Operations Support Project has found that costs per potential beneficiary for PVO projects average US $6. How the range and volume of services provided by PVOs supported by the PVO Child Survival Operations Support Project compare to the Dominican sample is unknown.

[13]Estimates of population from IEPD (1986). Malnutrition rates for each region were calculated by CENISME (1990). Number of pregnant and breastfeeding women based on estimated number of births for 1990 (IEPD, 1986) multiplied by a factor of 1.7. Assumes constant fertility rates over five-year period (DHS, 1986), fetal loss of 20 percent (international standard), and period of greatest importance for lactation support is 0-6 months.

The important point here is the need for PVOs to collect and analyze cost data. Currently, costs are considered a given, in part because they are generally unknown to PVO executives. The only solution posed by executives to counteract the reduction in (external) funding is to find alternative sources of financing to cover costs. An important question is whether the PVOs should first attempt to analyze and perhaps lower their costs before exploring methods to cover (or recover) them. When making decisions regarding expanding, maintaining, limiting, or eliminating activities, it is imperative to have information on costs. Without cost data, determining which activities are sustainable is nearly impossible.

4.3 ADMINISTRATIVE EXPENSES

Administrative expenditures as a percent of total (institutional) outlays provides a broad measure of efficiency. These outlays generally correspond to central office personnel and supplies, or similarly, to expenses that are not directly related to executing a program. As demonstrated in Exhibit 4-3, administrative costs as a share of total expenditures range from 7 to 60 percent. Again, the reader is cautioned that distinguishing between administrative overhead and program expenditures was not an easy task. Accounting systems varied considerably in content, form, and quality among the PVOs. For most, administrative overhead was allocated to programs on a prorated basis. Financial ledgers did not permit estimation of administrative outlays for IDDI, FEDES, and COIN.

EXHIBIT 4-3
ADMINISTRATIVE EXPENDITURES AS PERCENT OF TOTAL INSTITUTIONAL EXPENDITURES: SELECTED PVOs, 1990

PVO	PERCENT ADMINISTRATIVE EXPENDITURES
ACEBIEN	7%
CIAC	16
FUDECO	22
FH	25
ADOPLAFAM	30
PROFAMILIA	31
MUDE	33
CARE	60

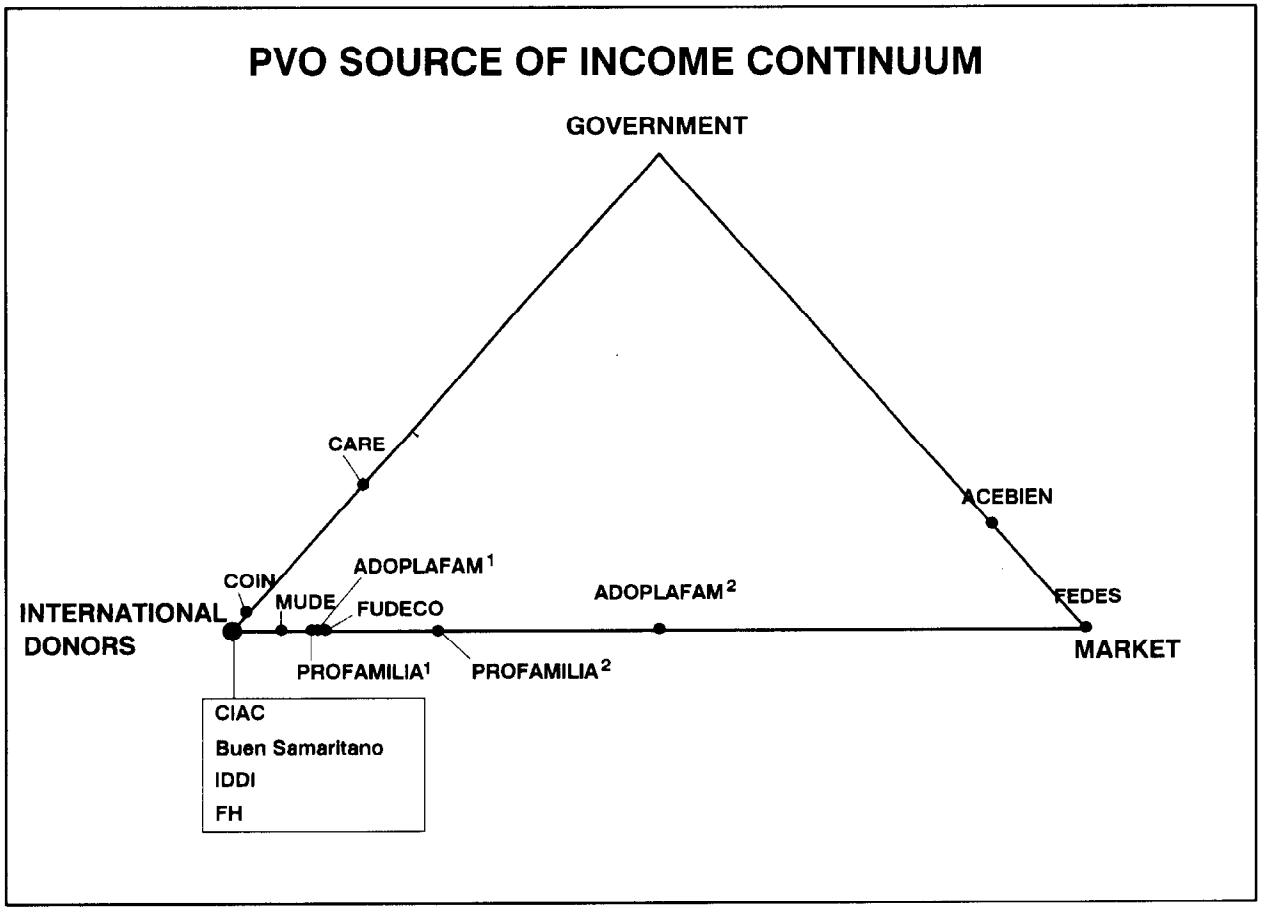
Despite the caveats, the wide differences may indicate the PVOs have room to achieve greater efficiency. Comparing PVOs conducting similar types of activities is instructive. For example, PROFAMILIA and ADOPLAFAM, PVOs that focus on family planning activities, spend nearly equivalent proportions of total expenditures on administrative overhead. FH, FUDECO, and MUDE are integrated development PVOs that operate programs related to health, agriculture, education, and general community development in rural areas. Compared to FUDECO and FH, which spend 22 and 25 percent of expenditures on administration, MUDE spends 33 percent. The high administrative costs may to relate to MUDE's management of nine projects financed by eight different external and national donors. Although two other PVOs, IDDI and FUDECO, have the same number of donors (8), these PVOs channel resources to a limited number of projects. In these cases, resources from two or more donors support a single activity. CARE's high administrative outlays correspond to management costs of food supplementation activities. Interestingly, ACEBIEN also manages (the sale) of food commodities, but this PVO's administrative overhead represents the lowest

portion in the sample. As described in the profiles, ACEBIEN is a sophisticated operation that approaches the efficiency of a well-operated private business. CIAC demonstrates a relatively low share of administrative expenses in part because most program directors and technical staff receive part-time compensation.

4.4 SOURCES OF INCOME

Despite their diversity in financial arrangements, development approaches, and activities, patterns emerge from the current sample of PVOs that allow for an analysis of the factors that facilitate financial survival. Exhibits 4-4 and 4-5 are attempts at conceptualizing and comparing the dimensions, magnitude, and frontiers of financial sustainability represented by the PVOs under study here. As shown in Exhibit 4-4, these PVOs derive their income from three categorical sources: international donor agencies, government, and private market revenues.

EXHIBIT 4-4



PROFAMILIA: (1) Institution; (2) Community-based promoters and clinic programs.
ADOPLAFAM: (1) Estimate for institution; (2) Estimate for Community Clinic Program.

Source: Adopted from Brody & Weiser and Martha Rose (1990)

The placement of the PVO in Exhibit 4-4 relates to the percent distribution of total financing derived from a particular source. Most PVOs received financing from one or two sources and thus are placed on an axis line. The figure does not, however, depict that MUDE, FUDECO, and IDDI receive financing from the government because the amounts are minimal or represent one-time transfers. Local donations represent an insignificant contribution to total income (see Exhibit 4-5). In some cases, volunteer labor and contributions from the community are an additional source of resources. Data and time limitations did not allow for an analysis of the incidence and value of these contributions, however.

Exhibit 4-5 shows the distribution of income by major categorical source. It complements the continuum presented in Exhibit 4-4, displaying a more detailed perspective on sources of financing. For most PVOs, international donors represent over 90 percent of income in 1990. Several are heavily dependent on a single donor (e.g., CIAC, FH, and Buen Samaritano). Income derived from local (charitable) sources, government, and market revenues are minimal for most PVOs.

A strategy currently fashionable among PVOs is to extend their base of donor support, or similarly, to limit their dependency on any single donor. PVO executives with many years of experience are unanimous in their rejection of reliance on a single (donor) source. They also are distrustful of government for anything other than a one-time transfer. Often income from three or more donors is used to maintain activities of a single program, thus guaranteeing some protection against the conditions and instability of a single donor. FUDECO, MUDE, and IDDI have embraced this strategy.

Executives from these organizations maintain that diversifying donor sources has been a successful short-term solution to counteract reductions from a former (single) donor. This strategy, however, has several disadvantages. It favors larger PVOs that have a permanent administrative staff (with the technical capacity to prepare proposals), the resources to afford international travel, and officers who speak one or more foreign languages. Few PVOs have the human and financial resources required to develop and market proposals on a sustained basis. Moreover, even those PVOs that are successful at this strategy admit that securing grants has become increasingly difficult. Moreover, competition for access to multiple donors creates jealousies among the PVOs that often impede coordination and cooperation. This is especially the case for PVOs performing similar activities in the same region. As suggested earlier, links to multiple donors may raise administrative costs because most donors require specific management and accounting systems.

EXHIBIT 4-5
ESTIMATED DISTRIBUTION OF PVO FINANCING BY SOURCE, 1990
(in percentages, rows add to 100%)

PVO	INTERNATIONAL DONORS		LOCAL DONORS	GOVERN-MENT	MARKET
	MAIN SOURCE	OTHER SOURCES			
ACEBIEN	0	0	0	20[1]	80
ADOPLAFAM	90		0	0	10
BUEN SAM.	99	0	0	0	<1
CARE	63	0	0	37	0
CIAC	80	9	10	0	0
COIN	90	5-7	0	2-5	0
FEDES	0	0	0	0	100
FH	90	9	1	0	0
FUDECO	60	35	<1	<1	<3
IDDI	70	24	1	5[2]	0
MUDE	37	56	1	3	<1
PROFAMILIA	92		0	0	8

[1] Estimate of indirect tax subsidy.
[2] One-time transfer.

Despite the drawbacks, obtaining support from multiple international aid agencies and charitable organizations appears to be the sustainability strategy taken by several PVOs (e.g., CIAC, FH, and Buen Samaritano) which are currently dependent on a limited number of donors.

Given the context of declining donor support described earlier in this paper, Exhibits 4-4 and 4-5 suggest a hypothesis: *financial* sustainability may be linked to a PVO's ability to achieve a workable balance of financing arrangements. In other words, a PVO that can derive a significant share of income from two or more *categorical* sources — international donors, local donors, government, and market revenues — may have a greater opportunity for securing resources for institutional and programmatic sustainability.

The current sample provides some evidence to support this hypothesis. Both CIAC and Buen Samaritano had to abandon programs and communities when donor-supported projects terminated during the late 1980s. They were unable to tap other sources including alternative donors. A single categorical source is considered an at-risk position even for FEDES, which relies solely on market revenues. CEICES, the forerunner of FEDES, went bankrupt due to the country's severe economic downturn of 1990. FEDES directors currently are preparing proposals for financing through local and international donors. Since USAID plans to terminate its Child Survival Project, many of the PVOs participating in

the project will be forced to seek alternative sources of income to maintain child survival activities.

It is worth repeating that diversification does not necessarily imply securing multiple donors. For example, IDDI, CIAC, FUDECO, Buen Samaritano, and ADOPLAFAM seek to diversify through strengthening income received through market mechanisms and establishing links to government and local donors. FUDECO has established a business venture in which products produced by its affiliated cooperatives are sold in Santo Domingo. Buen Samaritano has recently purchased a site to establish a bakery. IDDI is exploring formal linkages with SESPAS whereby the latter supplies physicians and other professionals to staff IDDI clinics. CIAC has successfully tapped local charitable organizations to support its programs. Many are considering charging fees for some health services.

The reader should keep in mind, however, that many PVO services, target groups and geographical areas of coverage, respond to a combination of government inadequacy, market failure, and donors' programmatic agendas. Operationally, PVOs respond to needs not being met by government and the private for-profit sector. Often, PVOs define their principal activities, preventive and promotional health services, as social goods rather than market goods. By this account, they reject charging for these services, maintaining that fees are inappropriate.

The remainder of this section discusses the PVOs in terms of the conceptual maps set forth in Exhibit 4-4. As evident in the exhibit, most PVOs derive their income from a single categorical source. Several receive funding from two sources. We first describe the PVOs that correspond to the former category, that is, are located on one of three angles. We then discuss the PVOs who receive funding from more than a single funding source.

4.4.1 Single Categorical Income Source

- International donors: Nine of the 12 sampled PVOs derive all or a considerable proportion of income from international donor agencies. Financing can include grants for general support, capital investment, and program-specific activities. Generally, PVO health programs are sponsored in full by one or more donors. For example, external donors are the only source of income for health programs implemented by the sampled PVOs except for CARE, ACEBIEN, and PROFAMILIA.[14]

- Government: Government funding can consist of direct transfers or indirect support through tax breaks and other subsidy mechanisms. No PVO in the sample derives all income from government sources. All the PVOs providing child survival services collaborate to some extent with SESPAS. For example, SESPAS has assigned vaccination coverage responsibility for specific communities and subregions to PVOs active in these areas. FH and FUDECO manage vaccination

[14]FEDES does not perform health activities. Family Planning programs conducted by ADOPLAFAM derive an undetermined amount of income from sales.

campaigns in over 100 rural communities in the Province of Elias Piñas on the Haitian border.

- Private market revenues: These consist of earnings derived from sales, membership dues, fees, and business ventures. FEDES is the only PVO of the sample that depends totally on market revenues. FEDES provides training in management and business administration to PVOs, private firms, and public enterprises. Charges for training sessions and ongoing courses represent the institution's only source of income. According to FEDES directors, self-financing is part of its institutional philosophy. However, as suggested above, since FEDES is essentially a private business venture, it is subject to the vagaries of the marketplace. To be sure, its predecessor, CEICES, a for-profit firm that provided human resource and administrative training to private firms, was a victim of the severe economic downturn of 1989-1990. At that time, many firms reduced or terminated spending on human resource development.

4.4.2 Multiple Categorical Income Sources

Several PVOs receive funding from two of the three categorical sources displayed in Exhibit 4-4. These include: CARE, ACEBIEN, ADOPLAFAM, PROFAMILIA, FUDECO, and COIN. Each is discussed in turn.

CARE is the only PVO receiving direct transfers from government agencies. Representing nearly 40 percent of income in 1990, these disbursements are earmarked for CARE's food supplementation activities. International donors represent the remaining sources of income. Food is distributed to target groups through the government network of rural health clinics, preschools, and elementary schools. The government also supports CARE through the provision of physical plant.

ACEBIEN's income is derived from food product sales, the purchase of food coupons, and monthly membership fees. These goods and services are purchased by formal sector firms, and to a lesser extent, by their employees. ACEBIEN receives no external funding or direct government support. Nevertheless, the government indirectly subsidizes ACEBIEN through tax advantages granted to ACEBIEN's member firms. Since these purchases are classified as "donations" to ACEBIEN, they are tax-deductible under Dominican tax law. It is this tax advantage that provides a major incentive to firms to enroll in ACEBIEN and purchase its services. Without a more detailed study, it is difficult to estimate the percent subsidy. Without the tax advantage, firms' demand for ACEBIEN goods and services probably would decrease.

ADOPLAFAM receives a large but undetermined amount of income from external sources. It operates two programs, however, that incorporate cost recovery through market mechanisms. Data limitations do not allow for a precise estimate of market revenues. In one program, ADOPLAFAM has trained 165 beauty salon operators in family planning promotion. In addition to providing orientation and referrals (to ADOPLAFAM clinics), these promoters sell contraceptives supplied by ADOPLAFAM. The contraceptives themselves are donated through AID/Washington,

but the cost of commodity management is recovered through sales to the promoters. Promoters retain a 50 percent commission on the sales.

ADOPLAFAM's Community Clinic Program represents another case of joint international donor/market financing. Through donor support, the PVO incurs all the costs of establishing a clinic (recruitment, supplies, equipment, remodeling, training, etc.). ADOPLAFAM's initial strategy involves achieving self-sufficiency for the clinics through recovering all operating costs by charging user fees. Therefore, sustainability is reached in the sense that the clinic is no longer dependent on the PVO for financing operations. In addition, income generated from fees for the first 120 visits is redirected to ADOPLAFAM, permitting it to recover an undetermined proportion of the original investment. Further, after achieving operational self-sufficiency, a clinic's physician has a buy-out option. He or she can assume proprietorship of the clinic through the purchase of the equipment at cost from ADOPLAFAM.

Although PROFAMILIA as an institution is strongly dependent on external donors, it has made great strides in achieving adequate levels of cost recovery through market revenues. In 1990, it recovered approximately 30 percent of recurrent expenditures in the Evangelina Rodriguez and Rosa Cisneros clinics through user fees. Similar to ADOPLAFAM's beauty salon-based promoters, PROFAMILIA also provides family planning orientation and commodity distribution through a large network of trained, community-based promoters. PROFAMILIA recovers about 16 percent of the cost of commodity management through sales to its promoters. Promoters retain 71 percent commission on the prices of contraceptives and 60 percent on condoms. Taken together, the clinic- and promoter-based family-planning programs recover approximately 25 percent of operating costs. These figures do not include the value of the contraceptives, which are donated through AID.

FUDECO secures approximately 90 percent of its income from donor assistance, including loans. The rest is derived from business ventures which the PVO is ardently pursuing as alternative financing mechanisms. FUDECO recently established an enterprise involving the production and sale of cheeses and cured meats. These items are produced in collaboration with a network of cooperatives and producer associations affiliated with FUDECO and are sold through a retail outlet in Santo Domingo. Although data on costs and revenues were unavailable, FUDECO administrators claim that the operation is self-sufficient. FUDECO also manages a number of experimental farms that are partly financed through sales and the use of volunteer labor. FUDECO works through peasant organizations, cooperatives, and producer associations that receive training from the PVO, but these groups are responsible for providing labor, food, housing, and local materials. The value of these donations is unknown.

COIN emerged from a state agency responsible for the control and prevention of STDs. COIN operates clinics in partnership with SESPAS which assigns and pays for physicians as well as underwrites part of the cost of equipment and supplies. Token fees are charged for medical visits. No data were available on revenues.

MUDE, IDDI, and FUDECO have established income-generating credit funds. Money is lent to micro-enterprises, farmers, and small groups at below-market interest rates. These PVOs derive income from the interest earnings. These are

relatively recent endeavors, however, and have yet to reach self-sufficiency. Since the credit programs charge below market rates of interest, they should not be expected to generate revenue for health services.

4.5 OPTIONS FOR FINANCIAL SUSTAINABILITY

PVOs tend to view their current predicament of decreasing support from USAID in terms of expanding ties to other donors. Alternative strategies would include: (1) monitor and reduce costs; and (2) diversify financial arrangements through market revenues and through stronger linkages with government.

Monitor Costs and Increase Efficiency: PVOs need to place greater priority on quantifying existing costs of activities and exploring how to provide services more efficiently. Since costs are generally unknown to PVO executives, they are unable to identify or compare alternatives according to least-cost criteria. Without cost information, cost-efficient considerations regarding which activities to maintain and how to maintain them are absent from the decision-making process.

The brief analysis of PVO expenditures presented here suggests a wide range in direct and indirect costs among PVOs delivering similar services. These variations were attributed to differences in the value of incentives provided to "volunteer" promoters, promoter-family ratios, and supervisor-promoter ratios. Other factors may also contribute to costs but the absence of detailed data from the PVOs precluded more in-depth analysis. The analysis suggests that efficiency gains are possible. To determine how to capture those gains, PVOs need to measure real population coverage, staff productivity, and the unit costs of activities provided. Allocating administrative and investment costs to service production should receive high priority to provide a more precise estimate of total costs. In general, PVOs need technical and managerial support to strengthen their capacity to deliver services in a least-cost manner.

Diversify Sources of Financing: Based on the Dominican experience, integration of charitable, private market, and public sources of income may represent a viable strategy for achieving financial sustainability. Such a strategy can provide a financial safety net to protect the PVO (and its programs) against a cutback from any one source. The proposed strategy does not suggest that international aid agencies will abandon their current PVO orientation. Indeed, it may be unrealistic to hope that most PVOs can sustain operations through state and market sources with little or no donor support. The financial role of the international aid agencies and charitable organizations in the Dominican Republic will persist, albeit with decreasing importance. Moreover, given the current concern for financial sustainability and matching funds among large aid agencies, any PVO that derives income from other (market and government) mechanisms has a greater chance of obtaining their support.

How a PVO is linked to the government as well as what type of market mechanism(s) is employed are important issues facing these organizations. The remainder of this section examines four options: business ventures, user fees, linkages to local organizations/private firms, and linkages to government. It is worthy of comment that these options are not mutually exclusive. Interaction can occur at many levels.